CHAPTER 45-06-11
REGULATION ON THE CREDITING OF QUALIFYING PREVIOUS COVERAGE TOWARD THE REDUCTION OF PREEXISTING CONDITION EXCLUSION PERIODS

45-06-11-01. Definitions. As used in this chapter:

1. "Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

2. "First day of coverage" means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

3. "Health carrier" means any entity that provides health insurance in this state. For purposes of this chapter, "health carrier" includes an insurance company, a prepaid limited health services corporation, a fraternal benefits society, a health maintenance organization, a nonprofit health services corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

4. "Late enrollee" means an individual whose enrollment in a plan is a late enrollment.

5. "Late enrollment" means enrollment under a group health plan other than on the earliest date on which coverage can become effective under the terms of the plan, or a special enrollment date for the individual. If an individual ceases to be eligible for coverage under the plan by terminating employment, and then subsequently becomes eligible for coverage under the plan by resuming employment, only eligibility during the individual's most recent period of employment is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

6. "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

7. "Waiting period" means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

History: Effective December 1, 1997; amended effective October 1, 2002.
General Authority: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04
Law Implemented: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04

45-06-11-02. Methods of crediting coverage.

1. Any health carrier offering health insurance in this state must reduce any time period applicable to a preexisting condition exclusion or limitation period by the aggregate of periods the individual was covered by qualifying previous coverage, if any, if the qualifying previous coverage was continuous until at least sixty-three days prior to the effective date of the new coverage. The health carrier must credit coverage by either a standard or alternative method.

2. A health carrier electing to credit coverage by the standard method shall determine the amount of qualifying previous coverage without regard to the specific benefits covered during the period of qualifying previous coverage.

3. For purposes of reducing the preexisting condition exclusion period under the standard method, a health carrier determines the amount of qualifying previous coverage by counting all the days that the individual has under one or more types of qualifying previous coverage. If an individual is covered by more than one source of qualifying previous coverage on any given day, all the qualifying previous coverage on that day is counted as one day. Days spent in a waiting period for a plan or policy are not days of qualifying previous coverage.

4. Days of qualifying previous coverage occurring before a significant break in coverage are not required to be counted by the plan or issuer in reducing the preexisting condition exclusion. A significant break in coverage means a period of sixty-three consecutive days during all of which the individual was not covered by any qualifying previous

coverage. Waiting periods are not taken into account in determining a significant break in coverage.

5. A health carrier offering health insurance in this state may elect to use an alternative method of crediting coverage. In applying the alternative method, coverage may be credited based on coverage of benefits within the following five categories of benefits:

   a. Mental health;

   b. Substance abuse treatment;

   c. Prescription drugs;

   d. Dental care; or

   e. Vision care.

   Any health carrier offering health insurance in this state may use the alternative method for any or all of the five categories and may apply a different preexisting condition exclusion with respect to each category. The qualifying previous coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. For coverage that is not within the above categories, qualifying previous coverage is determined by using the standard method. A health carrier using the alternative method is required to apply it in a uniform manner.

6. Under the alternative method, the health carrier counts qualifying previous coverage within a category if any level of benefits is provided within a category. The health carrier first determines the amount of the individual's qualifying previous coverage that may be counted under the standard method, up to a total of three hundred sixty-five days of the most recent qualifying previous coverage. The period over which this qualifying previous coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the health carrier counts within the category all days of coverage that occurred during the determination period, whether or not a significant break in coverage for that category occurs, and reduces the individual's preexisting condition exclusion period for that category by that number of days.

7. A health carrier electing to credit coverage using the alternative method is required to:

   a. State prominently that the health carrier is using the alternative method of counting qualifying previous coverage in disclosure statements concerning the health insurance coverage, and state

this to each enrollee at the time of enrollment under the coverage; and

b. Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

8. A health carrier may determine the amount of qualifying previous coverage in any other reasonable manner that is at least as favorable to the individual as long as the issuer applies the method uniformly.

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General Authority: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04
Law Implemented: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04

45-06-11-03. Certification of coverage in the individual market.

1. This section applies to all health carriers offering health insurance coverage in the individual market.

2. A certificate of coverage must be provided, without charge, for individuals and dependents, who are or were covered under an individual health insurance policy, for the following:

a. An automatic certificate must be provided within a reasonable period of time after the individual ceases to be covered under the policy; and

b. A certificate of coverage must be provided upon request if the request is made, by or on behalf of an individual, within twenty-four months after coverage ends.

c. A certificate of coverage issued under this section must be provided in writing. However, a written certificate is not required if:

(1) The individual is entitled to receive a certificate of coverage;

(2) The individual requests that the certificate be sent to another plan or health carrier instead of to the individual;

(3) The plan or health carrier agrees to accept the information through means other than a written certificate; and

(4) The plan or health carrier receives the certification within a reasonable time.

d. A certificate of coverage issued under this section must include the following information in a form similar to that shown in appendix A:

(1) The date on which the certificate is issued;

(2) The name of the individual or dependent to whom the certificate applies and any other information necessary to identify the individual;

(3) The name, address, and telephone number of the issuer of the certificate;

(4) A telephone number to call for further information;

(5) The date the qualifying previous coverage ended, unless the certificate indicates that the qualifying previous coverage is continuing as of the date of the certificate; and

(6) Either one of the following statements:

(a) A statement that the individual has at least eighteen months of qualifying previous coverage; or

(b) Both the date the individual first sought coverage, as evidenced by a substantially complete application, and the date qualifying previous coverage began.

e. If an automatic certificate is provided under this section, the period that must be included on the certificate is the last period of continuous qualifying previous coverage ending on the date coverage ceased.

f. If an individual requests a certificate under this section, a certificate must be provided for each period of continuous qualifying previous coverage ending within the twenty-four-month period ending on the date of the request. A separate certificate may be provided for each such period of continuous qualifying previous coverage.

g. A health carrier may provide a single certificate for both an individual and the individual's dependents if it provides all the required information for each individual and dependent, and separately states the information that is not identical.

h. The certificate is required to be provided, without charge, to each individual described in this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the individual and the individual's spouse at the individual's last-known address, the requirements of this section are satisfied with resect to all individuals residing and dependents at that address. If the dependent's last-known address is different than the individual's last-known address, a separate certificate

is required to be provided to the dependent at the dependent's last-known address.

i. A health carrier must establish a procedure for individuals to request and receive certificates under this section.

j. If an automatic certificate is required to be provided under this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the health carrier responsible for providing the certificate is permitted to provide the certificate to the designated party.

k. If a certificate is required to be provided upon request under this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the health carrier responsible for providing the certificate is required to provide the certificate to the designated party.

l. A health carrier is required to use reasonable efforts to determine any information needed for a certificate relating to the dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under this section, no individual certificate is required to be furnished until the health carrier knows, or making reasonable efforts should know, of the dependent's cessation of coverage under the plan.

m. If a certificate furnished by a health carrier does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within thirty days of birth, adoption, or placement for adoption.

n. A health carrier that cannot provide the names of dependents, or related coverage information, for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of this section by providing the name of the participant covered by the health carrier and specifying that the type of coverage described in the certificate is for dependent coverage. This subdivision is in effect through June 30, 1998.

o. For purposes of certificates provided at the request of, or on behalf of, an individual in this section, a health carrier must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate if such information is requested to be provided. If the certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described

in this section for submitting documentation to establish that the qualifying previous coverage in the certificate applies to the dependent.

p. A health carrier providing an automatic certificate that does not contain the name of a dependent must furnish a certificate within twenty-one days after the individual ceases to be covered under the policy.

q. If an individual enrolls in a group health benefit plan with respect to which the plan or health carrier uses the alternative method of counting qualifying previous coverage described in this section, the individual provides a certificate of coverage under this section, and the plan or health carrier in which the individual enrolls so requests, the entity that issued the certificate, the "prior entity", is required to disclose promptly to a requesting plan or health carrier, the "requesting entity", the information set forth in this section. The prior entity furnishing the information under this subsection may charge the requesting entity for the reasonable cost of disclosing such information.

r. Every health carrier must allow individuals to establish qualifying previous coverage by means other than a certificate. The health carrier is required to take into account all information that it obtains or that is presented on behalf of an individual in making its determination, based on the relevant facts and circumstances, whether the individual has qualifying previous coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. The health carrier shall treat the individual as having provided a certificate if the individual attests to the period of qualifying previous coverage, presents relevant corroborating evidence, and cooperates with the plan or health carrier's efforts to verify the coverage. While a health carrier may refuse to credit coverage if the individual fails to cooperate with efforts to verify coverage, the health carrier may not consider an individual's inability to obtain a certificate as evidence of the absence of qualifying previous coverage.

History: Effective December 1, 1997; amended effective October 1, 2002.
General Authority: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04
Law Implemented: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04

45-06-11-04. Certification of coverage in the group market.

1. A health carrier offering group health insurance coverage under a group health benefit plan is required to provide certificates of qualifying previous coverage in accordance with this section.

2. Any entity required to provide a certificate under this section for an individual is deemed to have satisfied the requirements of this section for that individual if another party provides the certificate, but only to the extent the information related to the individual's qualifying previous coverage and waiting period is provided by the other party.

3. A health carrier is not required to provide information regarding coverage provided to an individual by another party.

4. If an individual's coverage under a health carrier's policy ceases before an individual's coverage under the plan ceases, the health carrier is required to provide sufficient information to the plan to enable a certificate to be provided by the plan, after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy.

5. A certificate of coverage must be provided, without charge, for individuals and dependents, who are or were covered under a group health insurance policy, for the following:

   a. An automatic certificate must be provided in the following circumstances:

      (1) In the case of an individual who is a qualified beneficiary entitled to elect Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of Consolidated Omnibus Budget Reconciliation Act continuation coverage or alternative coverage elected instead of Consolidated Omnibus Budget Reconciliation Act continuation coverage.

      (2) In the case of an individual who is not a qualified beneficiary entitled to elect Consolidated Omnibus Budget Reconciliation Act continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan. A health carrier satisfies this requirement if it provides the certificate within a reasonable time period after the individual ceases to be covered under the plan. In the case of an individual who is entitled to elect continuation coverage under North Dakota Century Code section 26.1-36-23 or 26.1-36-23.1, an automatic certificate is required to be furnished no later than thirty-one days after the individual ceases to be covered under the plan.

      (3) In the case of an individual who has elected Consolidated Omnibus Budget Reconciliation Act continuation coverage, an automatic certificate must be provided at the time the

individual's coverage under the plan ceases. The health carrier satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases. An automatic certificate is required to be provided to an individual regardless of whether the individual has previously received an automatic certificate.

b. A certificate of coverage must be provided upon request if the request is made, by or on behalf of an individual, within twenty-four months after coverage ends.

6. A certificate of coverage issued pursuant to this section must be provided in writing. However, a written certificate is not required if:

a. The individual is entitled to receive a certificate of coverage;

b. The individual requests that the certificate be sent to another plan or health carrier instead of to the individual;

c. The plan or health carrier agrees to accept the information through means other than a written certificate; and

d. The plan or health carrier receives the certification within a reasonable time.

7. A certificate of coverage issued under this section must include the following information in a form similar to that shown in appendix B:

a. The date on which the certificate is issued;

b. The name of the individual or dependent to whom the certificate applies and any other information necessary to identify the individual;

c. The name, address, and telephone number of the issuer of the certificate;

d. A telephone number to call for further information;

e. The date qualifying previous coverage ended, unless the certificate indicates the qualifying previous coverage is continuing as of the date of the certificate; and

f. Either:

(1) A statement that the individual has at least eighteen months of qualifying previous coverage; or

(2) The date any waiting period began and the date qualifying previous coverage began.

8. If an automatic certificate is provided under this section, the period that must be included on the certificate is the last period of continuous qualifying previous coverage ending on the date coverage ended.

9. If an individual requests a certificate under this section, a certificate must be provided for each period of continuous qualifying previous coverage ending within the twenty-four-month period ending on the date of the request. A separate certificate may be provided for each such period of continuous qualifying previous coverage.

10. A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

11. The certificate is required to be provided to each individual described in this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last-known address, the requirements of this section are satisfied with respect to all individuals residing at that address. If the dependent's last-known address is different than the participant's last-known address, a separate certificate is required to be provided to the dependent at the dependent's last-known address.

12. A health carrier must establish a procedure for individuals to request and receive certificates under this section.

13. If an automatic certificate is required to be provided under this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the health carrier responsible for providing the certificate is permitted to provide the certificate to the designated party.

14. If a certificate is required to be provided upon request under this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the health carrier responsible for providing the certificate is required to provide the certificate to the designated party.

15. A health carrier is required to use reasonable efforts to determine any information needed for a certificate relating to the dependent coverage. In any case in which an automatic certificate is required

to be furnished with respect to a dependent under this section, no individual certificate is required to be furnished until the health carrier knows, or making reasonable efforts should know, of the dependent's cessation of coverage under the plan.

16. If a certificate furnished by a health carrier does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within thirty days of birth, adoption, or placement for adoption.

17. A health carrier that cannot provide the names of dependents, or related coverage information, for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of this section by providing the name of the participant covered by the health carrier and specifying that the type of coverage described in the certificate is for dependent coverage. This subsection is in effect through June 30, 1998.

18. For purposes of certificates provided on the request of, or on behalf of, an individual in this section, a health carrier must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate when such information is requested to be provided. If the certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in this section for submitting documentation to establish that the qualifying previous coverage in the certificate applies to the dependent.

19. Issuers of group and individual health insurance are required to provide certificates of any qualifying previous coverage they provide in the group or individual health insurance market even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because it is not subject to the group market provisions.

20. If an individual enrolls in a group health benefit plan with respect to which the plan or health carrier uses the alternative method of counting qualifying previous coverage described in this section, the individual provides a certificate of coverage under this section, and the plan or health carrier in which the individual enrolls so requests, the entity that issued the certificate, the "prior entity", is required to disclose promptly to a requesting plan or health carrier, the "requesting entity", the information set forth in this section. The prior entity furnishing the information under this subsection may charge the requesting entity for the reasonable cost of disclosing such information.

21. Every health carrier must allow individuals to establish qualifying previous coverage by means other than a certificate. The health carrier

is required to take into account all information that it obtains or that is presented on behalf of an individual in making its determination, based on the relevant facts and circumstances, whether the individual has qualifying previous coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. The health carrier shall treat the individual as having provided a certificate if the individual attests to the period of qualifying previous coverage, presents relevant corroborating evidence, and cooperates with the plan or health carrier's efforts to verify the coverage. While a health carrier may refuse to credit coverage where the individual fails to cooperate with efforts to verify coverage, the health carrier may not consider an individual's inability to obtain a certificate as evidence of the absence of qualifying previous coverage.

22. Every health carrier offering health insurance on a group basis using the alternative method of crediting coverage is required to allow an individual to demonstrate categories of qualifying previous coverage in a fashion similar to that outlined in subsection 21. Likewise, a health carrier offering health insurance on a group basis must allow an individual to demonstrate dependent status in a fashion similar to that outlined in subsection 21.

History: Effective December 1, 1997; amended effective October 1, 2002.
General Authority: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04
Law Implemented: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04

45-06-11-05. Notification of qualifying previous coverage and preexisting condition exclusion period.

1. A health carrier is required, within a reasonable time, to make a determination regarding the individual's qualifying previous coverage and notify the individual of the determination in accordance with this section.

2. A health carrier seeking to impose a preexisting condition exclusion is required to disclose to the individual in writing its determination of any preexisting condition exclusion period that applies to the individual and the basis for such determination, including the source and substance of any information on which the health carrier relied. In addition, the health carrier is required to provide the individual with a written explanation of any appeal procedures established by the issuer and with a reasonable opportunity to submit additional evidence of coverage. Nothing in this section prevents a health carrier from modifying an initial determination qualifying previous coverage if it determines that the individual did not have the claimed qualifying previous coverage, provided that:

   a. A notice of reconsideration is provided to the individual; and

b. Until the final determination is made, the health carrier, for purposes of approving access to medical services, acts in a manner consistent with the initial determination.

History: Effective December 1, 1997.
General Authority: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04
Law Implemented: NDCC 26.1-08-12(4), 26.1-36.3-06(3)(b), 26.1-36.4-04

CERTIFICATE OF INDIVIDUAL HEALTH INSURANCE COVERAGE

***IMPORTANT**–This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll, if medical advice, diagnosis, care, or treatment was recommended or received for the condition during the six months before your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to establish your right to buy coverage for yourself or your family, with no exclusion for previous medical conditions, if you are not covered under a group health plan.

1. Date of this certificate: _____
2. Name of policyholder: _____
3. Identification number of policyholder: _____
4. Name of any dependents to which this certificate applies: _____
   _____
5. Name, address, and telephone number of issuer responsible for providing this certificate:
   _____
   _____
   _____
6. For further information, call: _____
7. If all individuals identified in lines 2 and 4 have at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here _____and skip lines 8 and 9.
8. Date coverage began: _____
9. Date that a substantially completed application was received from this policyholder: _____
10. Date coverage ended: _____ (or check here if coverage is continuing as of the date of this certificate: _____).

NOTE: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

***IMPORTANT**–This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. Identification number of participant: _____
5. Name of any dependents to which this certificate applies: _____
   _____
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
   _____
   _____
   _____
7. For further information, call: _____
8. If the individuals identified in line 3 and line 5 have at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here _____and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____ (or check here if coverage is continuing as of the date of this certificate: _____).

NOTE: Separtate certificates will be furnished if information is not identical for the the participant and each beneficiary.